CHAPTER 28

MEDICAL AND DENTAL CARE

(Sponsor: NAVY HEALTHCARE-SHA Med Pol HEO)

CONTENTS

Para

2801. Introduction
2802. Medical Force Generation
2803. References
2804. Royal Navy Medical Board of Survey and Royal Navy Medical Employability Board
2805. Provision of Medical Care
2806. Provision of Dental Care
2807. Medical Information - Disclosure to Command
2808. Adventurous Training and Sports
2809. Reserves
2810. Medical Welfare
2811. Dangerously Ill Forwarding of Relatives (DILFOR)
2812. Long Term Sickness
2813. Defence Mental Health Services
2814. Persons living with HIV (PLWH) - Employment at Sea
2815. Assisted Conception Services and Fertility Preservation
2816. Individual Medical Risk Assessment for Operational Deployments or High Readiness Roles

ANNEXES

Annex 28A: A Commander's Guide to Initiating Medical Risk Assessments
Annex 28B: RN Individual Medical Risk Assessment (MRA) Form

CHAPTER 28

MEDICAL AND DENTAL CARE

2801. Introduction

The Royal Navy Medical Service (RNMS), along with the wider Defence Medical Services (DMS), will provide healthcare, medical operational capability and healthcare advice to maximise the fighting power of the RN. This will be achieved through the delivery of Service-specific policy and advice to RN and Defence Primary Healthcare (DPHC) capabilities and the Force Generation and assurance of medical capability in RN assets and locations within the Integrated Global Defence Network (IGDN)[1]. This mission flows directly from the Defence Plan through to the Service Personnel Plan and features in the requirements of the Royal Navy Command Plan. The RNMS sets the healthcare and occupational standards required to deliver Service personnel who are medically and dentally fit for deployment and for the provision and/or delivery of primary, intermediate and secondary healthcare appropriate to the environment in which personnel are serving.

2802. Medical Force Generation

The RNMS is directed to ensure that the maximum number of personnel are medically fit for task. Joint Medical Employment Standards (JMES)[2] codes are used to define the medical employment standard appropriate to an individual's medical fitness and enable the communication of necessary information to the employer (Career Managers (CMs), Chain of Command (CoC)) without any breach of medical confidentiality. They ensure that the individual can be appropriately employed without unnecessarily endangering their own health or that of others and reduce risk to the operational commander by preparing individuals appropriately for endemic/environmental risks within the theatre of operations. To allow appropriate assignment action, CMs are provided with an individual serviceperson's JMES through JPA. Annex E to Footnote 2 provides a Commanders' Guide to interpretation of JMES and is a useful reference tool.

2803. References

a. **Tri-Service.** JSP 950[3] and the DPHC Handbook[4] remain the core healthcare texts for medical staff applicable across Defence and supplement the below single Service policies.

b. **Royal Navy and Royal Marines.** BRd 1991 (Instructions for the Royal Naval Medical Service)[5] and BRd 1750A (Handbook of Naval Medical Standards)[6] are the primary references for Royal Navy (RN) policy and organisation of RN Medical and Dental Care. They also contain the procedures and standards for the provision of medical and dental care to entitled personnel.

[1] https://modgovuk.sharepoint.com/sites/IntranetCSOC/SitePages/Integrated-Global-Defence-Network-Implementation-Order.aspx?web=1
[2] JSP 950 Leaflet 6-7-7. https://modgovuk.sharepoint.com/teams/3695/SitePages/JSP-950-Lft-6-7-7-Joint-Service-Manual-of-Medical-Fitness.aspx.
[3] https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950--Medical-Policy.aspx?OR=Teams-HL&CT=1675856139757.
[4] https://modgovuk.sharepoint.com/teams/6164/DC/SitePages/Handbook.aspx
[5] BRd 1991. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm
[6] BRd 1750A. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm

c. **Maritime Reserves.** For medical administration of Maritime Reserves see BRd 3(1) Chapter 102, Paras 10215-10219 (Full Time Reserve Service); Paras 10254-10257 (Additional Duties Commitment); BRd 3(2), Chapter 20, Paras 2016-2019 (Naval Careers Service).

d. **Royal Fleet Auxiliary.** See BRd 875.[7]

2804. Royal Navy Medical Board of Survey and Royal Navy Medical Employability Board

Whilst short term changes to medical grading and work limitations are made at Unit level, the assessment of any long-term impact to fitness or requirements for long-term restrictions on work ability is conducted in a two-stage process. This involves referral either to a single Service specialist in Occupational Medicine or the Royal Navy Medical Board of Survey (RNMBOS) which gives a medical recommendation on fitness in the form of a JMES. That recommendation is then considered by the Medical Employability Board (MEB), on behalf of the Royal Navy as the employer, and a decision taken as to whether the Service person can continue to be successfully employed within the JMES allocated. Details of the function and processes of the Boards are in BRd 1991 Chapter 8[8] and BRd 1750A Chapter 5[9].

2805. Provision of Medical Care

In partnership with others[10], the RNMS assures high quality healthcare to support force generation and maintain the health of the Royal Navy.

a. In the strategic base, Primary Healthcare (General Practice, Dental Care, Mental Health, Occupational Health, Public Health and Defence Rehabilitation) is provided to entitled personnel by Defence Primary Health Care (DPHC). The RNMS retains responsibility for the provision of primary healthcare and occupational health to deployed Royal Navy, RFA, Royal Navy Reserve[11] and other personnel, subject to eligibility.[12] DPHC output is audited against performance indicators agreed on a tri-Service basis.

b. Access to timely Secondary Healthcare in the UK at least equivalent to that provided by the National Health Service (NHS).

c. All Royal Navy personnel are directed to carry a valid Global Health Insurance Card (GHIC) (or an in-date European Health Insurance Card (EHIC) until these are phased out).[13] Service personnel are strongly advised to hold appropriate travel insurance when travelling anywhere at their own expense, engaged in activities off duty or non-Service reasons.

[7] BRd 875 Regulations for Royal Fleet Auxiliaries. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm
[8] BRd 1991 Instructions for the Royal Naval Medical Service
[9] http://web.apps.royalnavy.r.mil.uk/fpgo/BRd_0001_4999/BRd_1750a/BRd_1750a/BRd_1750a.pdf
[10] DPHC, NHS, Private Providers, third sector, coalition partners.
[11]. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950--Medical-Policy.aspx
[12] https://modgovuk.sharepoint.com/sites/IntranetHeadOffice/SitePages/JSP-770.aspx
[13] https://www.gov.uk/government/news/uk-launches-global-health-insurance-card

d. The management of chronic conditions can be compromised by an assignment overseas. Before deploying overseas, the assigned Service Person is to make a declaration concerning their health and that of their dependants (if serving accompanied). All long-term medical conditions are to be declared in accordance with single Service procedures to allow the receiving Command to make an informed decision as to whether a chronic condition can be appropriately managed. Where a condition cannot be managed, a decision then must be made, by the assigning authority, as to whether the assignment can go ahead.

2806. Provision of Dental Care

Dental care is provided by Defence Primary Health Care (Dental) to all entitled personnel (DPHC Dental Leaflet, Chap 4, Annex B refers)[14] to a level of at least equivalent to that available via the NHS. Dental care can be provided whilst deployed if planned into the mission via the Fleet Dental Surgeon (BRd 1991 Ch15[15] provides the relevant process). It is important that every Service Person maintains their own level of dental fitness and arranges regular dental inspections at the interval set by their DPHC (Dental) clinician, the periodicity of which will be determined by the individual's clinical risk (JSP 950 2-23-1)[16].

2807. Medical Information - Disclosure to Command

All healthcare or other personal information received by Service and civilian medical personnel acting in a healthcare capacity from, or in relation to a patient, is to be treated as protected information. JSP 441[17] and JSP 950 Medical Policy[18] underwrite the RN requirements of good informational management. Personnel involved in Health and personnel support have a legal[19] as well as an ethical duty to comply with Caldicott Policy[20,21]. Professional duties around confidentiality are also described in guidance from the professional bodies (e.g. GMC[22], GDC[23], NMC[24], HCPC[25], GPhC[26] and MA Code of Practice[27]). This guidance is to be followed by Service and civilian healthcare personnel at all times.

[14] DPHC Dental Leaflet.https://modgovuk.sharepoint.com/:w:/r/teams/19905/_layouts/15/Doc.aspx?sourcedoc=%7BD99171A9-35DF-4746-8475-BFBEADB083AE%7D&file=Annex%20B%20Chapter%204.doc&action=default&mobileredirect=true
[15] BRd 1991 - Homepage
[16] https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950--Medical-Policy.aspx?OR=Teams-HL&CT=1675856139757
[17] https://jsp441.r.mil.uk/index.php?title=JSP_441
[18] https://modgovuk.sharepoint.com/sites/IntranetCSOC/SitePages/JSP-950-Volume-5--Quality-of-Care.aspx
[19] http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted.
[20] JSP 950 Lft 1-2-15. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JAP-950-Volume-1--Medical-Administration.aspx
[21] https://www.gov.uk/government/publications/the-caldicott-principles
[22] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice.
[23] https://www.gdc-uk.org/.
[24] https://www.nmc.org.uk/.
[25] http://www.hcpc-uk.co.uk/.
[26] https://www.pharmacyregulation.org/.
[27] BRd 1991 MA Code of Practice. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm

a. **Occupational Health (OH) Data.** Specific information types are releasable to Command. These relate to the communication of a serviceperson's fitness to work including any restrictions or medically recommended protections. An employer is required by law to receive OH guidance in support of its statutory responsibilities under the Health and Safety at Work Act (1974). The RN operates under JSP 375 and through BRd 10 in this regard, with medical OH policy outlined at BRd 1991 Ch 17. Examples of OH data which are not personal medical information are:

(1) The Joint Medical Employability Standard (JMES) and associated medical limitations.

(2) A serviceperson's engagement with and adherence to Health Surveillance (HS) programmes such as periodical audiometric hearing assessments; however, the medical detail within specific HS tests may remain protected.

(3) An Individual Medical Risk Assessment (MRA) completed prior to high readiness status, deployment or Leadership and Development course(s) as required. Para 2816 applies.

b. Except in limited circumstances, disclosure of personal medical information is contrary to the law and to the public interest. Loss of confidence by personnel in the confidentiality of their healthcare may result in medical conditions being concealed, with consequent risks to Unit safety and operational effectiveness.

c. Personal medical information may only be disclosed as follows:

(1) With the individual's valid consent.

(2) Where required under the law.

(3) Where substantial public interest demands disclosure without consent, particularly protection of:

(a) The operational capability (OC) of the Unit.

(b) Safety of other Unit personnel.

d. Disclosures made for OC or safety reasons must only be made directly to the Commanding Officer (CO).

e. Information disclosed to the CO is to be limited to that which is required for the protection of OC or the safety of Unit personnel.

f. The CO must respect the confidential nature of all information disclosed and must only communicate as much detail to other personnel as required to deliver essential purposes of protecting OC or the safety of Unit personnel.

g. The individual must be informed of the content of all disclosures of their personal medical information to Command, preferably prior to disclosure but in any event at the earliest reasonable opportunity. This decision/encounter must also be documented within the medical record.

h. Private medical information is not to be used to instigate disciplinary proceedings other than in exceptional circumstances with the advice of Navy Legal.

i. **Specific Instances.**

(1) **Drug and Alcohol Misuse.** When drug or alcohol misuse is disclosed during a clinical consultation, this information must only be disclosed to Command if the nature of the misuse threatens harm to other members of the Unit or to OC. Medical personnel must report drug and alcohol misuse when they become aware of such misuse outside of their medical capacity. An example of such a threat would be a pilot who proposed to fly an aircraft while intoxicated.

(2) **Emergency Contraception.** Requests by personnel for emergency contraception whilst operational must not be disclosed outside the consultation without the consent of the individual.

(3) **Criminal Offence/Service Offence/Misconduct - Transactional Sex.** JSP 769 Ch 4 Para 4.2 b. states that ‘paying for sexual services’ might be deemed a Service offence, misconduct or at worst a criminal offence and should be reported to the CoC. However, should an individual present to the medical centre or sickbay seeking medical advice/treatment (e.g. for a sexually transmitted infection (STI)), and as part of the consultation, it is believed that unacceptable sexual behaviours have occurred, **there remains a duty of medical confidentiality** as described above in paras a-i above and in BRd 1991 Ch 4 0406. This medical confidentiality overrides that of informing the CoC over an offence/misconduct, **unless** the nature of the misuse/abuse threatens harm to other members of the Unit or to OC.

(4) **Exceptions.** Breaching medical confidentiality **may** be justified:

(a) In the public interest e.g. preventing serious harm or death.

(b) Where the clinician believes there is an ongoing risk of abuse including safeguarding concerns.

(5) Vocational healthcare personnel are **not** obliged to report offences if discovered as part of medical management but should consider whether there is exceptional risk that warrants disclosure. Line and divisional management are to support healthcare personnel in this endeavour with advice and guidance from Navy Healthcare SHA MedLegal SMO as required.

2808. Adventurous Training and Sports

Military personnel undertaking correctly staffed and officially sanctioned Adventurous Training (AT) and sports are entitled to medical care at public expense. In some countries where these activities take place, however, the civil health infrastructure cannot provide a suitable level of care. Private medical facilities that can provide the required level of care may be available but proof of ability to pay is often required before treatment commences. Military teams venturing overseas are strongly advised to obtain private medical insurance - refer to JSP 419.[28] In addition, the MOD, awards and manages a Global Medical Support contract (GMSC) that enables access to and support with obtaining healthcare overseas whilst on duty. This provides a medical care provision and liaison whilst on duty abroad, where service care is not available, through a Guarantee of Payment (GoP) system with selected providers. The provider is also charged with delivering medical support to overseas travellers via a 24-hour helpline, staffed with clinical and logistical personnel to provide advice and guidance. GMSC information can be obtained by submitting an email request for information (RFI) to the RN Healthcare Med Op Cap multi-user mailbox. [29]

a. Personnel on Recovery Duties (PRD) under an Individual Recovery Plan (IRP) are to engage with their Medical Officer and/or HQ Medical Planning Team to discuss the AT activities in which they are planning to engage. This is to ensure that the appropriate risk assessment can be conducted, and the MO/Medical Planner may make an assessment of the appropriateness of those activities. An MO must be involved when a Service Person's medical category or condition may place the individual or team at increased risk of injury or illness. PRD often hold a JMES with the medical limitation 8203 (Fit travel outside UK on duty for adaptive sport/adventurous training/represent the Service following MRA) to proactively support this.

b. All RN/RM activities are to be conducted safely in line with JSP 375. Activities that may require GMSC information in support of the Medical Planning and Health Impact Assessment (HIA) Process include, overseas operations or exercises, Defence Engagement activities, duty travel, Defence Activity Other Than Operations (DAOTO), Overseas Adventure Training and Sport[30]. Information from the GMSC provider is to be sourced at least 8 weeks prior to the activity to support the medical planning process and define the recommended healthcare facilities. It is the responsibility of the originating organisation to ensure any overseas AT is reviewed by the relevant Command Medical Authority (CMA). The CMA HIA process is intended to support the CoC where any Risk to Life (RtL) is a factor and gives an insight in to any healthcare related areas of concern and available mitigations which will help inform the pre-deployment conditions check. Commanding Officers retain ownership of and responsibility for their plans and any risks inherent within them.

[28] https://modgovuk.sharepoint.com/sites/IntranetHeadOffice/SitePages/JSP-419.aspx
[29] NAVYMED-MEDOPCAPMAILBOX@mod.gov.uk
[30] RNTM 06-007/25 – Competent Medical Authority (CMA) Healthcare Impact Assessment (HIA) instructions for RN Units

c. The reporting Unit/Organisation are to raise a HIA assessment, involving a comprehensive Medical Plan which includes a Plan on a Page detailing the 7 capabilities of care. This is to be developed and scrutinised within the relevant 1* area prior to being submitted to the Navy Healthcare Med Op Cap Multi-user for CMA review, comment, advice and archiving. On receipt of the HIA, RN Healthcare will review the medical provisions detailed, assess the capabilities and grade the overall impact. Once assessed the HIA will be returned to the originator with the CMA's comments and assessment of residual impact. It is then for the originator to act on this assessment, ensuring the Delegated Duty Holder (DDH) is informed and raised through the Navy Command Duty Holding construct where applicable.

2809. Reserves

For members of the Reserve component of the Armed Forces undertaking sanctioned military activity (sports, adventurous training or military training) medical support is provided at public expense up to the point where the individual is fit to be discharged home to the care of their NHS GP. Long term health care is not provided by MoD to manage the consequences of injury or illness sustained by members of the Reserve component unless mobilised for operations; that responsibility lies with the NHS. JSP 753 applies (Tri Service Regulations for the Mobilisation of Reserves).[31]

2810. Medical Welfare

a. The patient's CoC is expected to be fully engaged in the needs of the Service person undergoing hospital care regarding:

(1) Welfare needs assessment.

(2) Response to requests for welfare support.

(3) Emotional and practical support.

(4) Liaison and referral to other agencies as appropriate.

b. Arrangements are in place in the form of Unit Liaison Officers for linkage between single Service Welfare organisations (RN FPS[32], AWS[33], RAF[34] and SSAFA[35]) (see Chapter 24 - Welfare).

2811. Dangerously Ill Forwarding of Relatives (DILFOR)

DILFOR is an allowance designed to help ease the emotional and financial burden of close family members of a Service person who is unexpectedly admitted to hospital. DILFOR is available to provide travel and subsistence to enable family members to visit the Service person. Details of DILFOR are contained in JSP 751 Part 1 Vol 1 Chapter 6[36]. This is raised by the CoC using detail from NOTICAS reporting, supported by MDT N1 Case Conference or timely communication with the Unit Medical Officer.

[31] https://modgovuk.sharepoint.com/sites/IntranetHeadOffice/SitePages/JSP-753.aspx
[32] https://modgovuk.sharepoint.com/sites/IntranetNavy/SitePages/RN-Family-People-Support.aspx
[33] https://www.army.mod.uk/support-and-training/welfare/
[34] https://modgovuk.sharepoint.com/sites/IntranetRAF/SitePages/RAF-Health-and-Wellbeing.aspx
[35] https://www.ssafa.org.uk/get-help/welfare-and-benefits
[36] https://modgovuk.sharepoint.com/sites/IntranetHeadOffice/SitePages/JSP-751.aspx

2812. Long Term Sickness

Each Service has in place comprehensive long-term sickness management policies which ensure that Service personnel who are long term sick are properly tracked, managed and supported. Further information relating to Long Term Sickness may be found at Chapter 33 Recovery Pathway (RN[37], Army[38], RAF[39]).

2813. Defence Mental Health Services

a. Service personnel who develop a mental health disorder may require specialist assessment and management. In the UK, Defence Healthcare Recovery Group (DHRG) delivers Mental Health Services, which operate through a network of Departments of Community Mental Health (DCMH). Detailed guidance on the provision and management of mental health services is contained in JSP 950 Leaflet 2-7-2[40] and BRd 1991 Ch 18.[41]

b. Each Base Port area has a DCMH to which Unit Medical Officers or MOD GPs can refer Service personnel. JSP 950 Leaflet 2-7-2[42] Section 4 details the care pathway and referral processes.

c. In some circumstances it will be appropriate to accompany a DCMH referral with an FMed 1041 Occupational Report in the same way the reports are provided to MO/GP where an individual's occupational performance at work should be considered. JSP 950 Leaflet 1-2-4[43] details the appropriate guidance, including at Annex A, a template of the report for completion.

d. RN operational mental health support is embedded within the Primary Care Receiving Facility (PCRF) or deployed Forward Mental Health Team (FMHT). Specialist pre, during and post mental health support can be accessed via one of the 6 Waterfront Logistics Support Group uniformed mental health nurses within SURFLOT, SUBFLOT, UKCF. Guidance on FMHT composition, utilisation, and actions can be found in BRd 1991 Ch 18.

e. Specific guidance **for Command** on the RN management of deliberate self-harm is located at Chapter 24 Annex 24D, with specific guidance for **healthcare professionals** at Appendix 1 to Annex 24D.[44]

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[37] http://web.apps.royalnavy.r.mil.uk/fpgo/BRd_0001_4999/BRd_0003/BRd_3_1/ch33.pdf
[38] https://modgovuk.sharepoint.com/teams/14540/Pers/ARC/SitePages/ARC.aspx.
[39] https://modgovuk.sharepoint.com/teams/14053/SitePages/Home.aspx
[40] JSP 950 Lft 2-7-2. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950-Volume-2--Clinical-Policy.aspx
[41] BRd 1991. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm
[42] JSP 950 Lft 2-7-2. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950-Volume-2--Clinical-Policy.aspx
[43] JSP 950 Lft 1-2-4 JSP 950 Volume 1: Medical Administration
[44] BRd 3(1). web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm

2814. Persons living with HIV (PLWH) - Employment at Sea

a. **References.**

(1) JSP 950 Leaflet 6-7-7 Section 5 Annex N.[45]

(2) BRd 1991 Chapter 16 - Public Health - Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS).[46]

(3) JSP 950 Leaflet 7-2-1 Guidance on Risk Assessment and Immediate Management of Needle Stick/Sharps/Blood/Bodily Fluid and Tissue Exposure Incidents.[47]

(4) JSP 950 Leaflet 6-8-1 Defence Medical Services Uniformed and Civilian Healthcare Workers: Tuberculosis and Blood-Borne Viruses Screening and Management.[48]

(5) BRd 9467 (FLAGOs) Chapter 19 Medical and Dental Arrangements Articles 1937 and 1941.[49]

b. The Equality Act 2010[50] does not allow discrimination against personnel on the grounds of HIV status. Personnel who are HIV positive will always be dealt with in accordance with the principles of medical confidentiality. Only Medical Branch staff and, if required, the CO will be made aware of the status of such individuals.

c. Persons becoming HIV positive In Service will be medically managed and graded in accordance with JSP 950 Leaflet 6-7-7 Section 5 Annex N. Assignment decisions are based wholly on the joint medical employment standard (JMES) as normal.

2815. Assisted Conception Services and Fertility Preservation

a. Information on Assisted Conception Services and Fertility Preservation for Armed Forces Personnel (AFP) is contained within JSP 661, Chapter 2 Section 5[51] This reference document contains policy and guidance on sexual reproduction matters where AFP have the potential to experience difficulties in initiating, accessing or continuing assisted conception services (ACS) due to the exigencies of Service life. The aim of the policy is to minimise personal disruption and to maximise chain of command (CoC) support, whilst ensuring Service commitments are met. This aim is governed by four overarching principles:

(1) ACS are not directly provided or funded by the Ministry of Defence.

[45] JSP 950 Lft 6-7-7. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950-Volume-6--Occupational-Medicine---Health.aspx
[46] BRd 1991. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm
[47] JSP 950 Lft 7-2-1. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950-Volume-7--Public-Health.aspx
[48] JSP 950 Lft 6-8-1. https://modgovuk.sharepoint.com/sites/IntranetUKStratCom/SitePages/JSP-950-Volume-6--Occupational-Medicine---Health.aspx
[49] BRd 9467. web.apps.royalnavy.r.mil.uk/fpgo/Pages/Index_NWP.htm
[50] https://www.gov.uk/guidance/equality-act-2010-guidance.
[51] JSP 661 Chapter 2 Section 5.. https://modgovuk.sharepoint.com/sites/IntranetHeadOffice/SitePages/JSP-661.aspx?web=1

(2) Access to treatment will be aligned to local NHS criteria aligned with the National Institute for Health and Care Excellence (NICE) fertility guidelines.

(3) Where possible, ongoing treatment for AFP or their partner/spouse, whether public or privately funded, should not be interrupted or delayed by Service activity.

(4) There is specific NHS provision for those personnel who have suffered genital injury as a result of their Service.

b. For the purposes of this policy, ACS is the name given to the variety of treatments in support of conception, such as In-Vitro Fertilisation (IVF) or Intrauterine Insemination (IUI). It also incorporates fertility preservation (FP) services such as cryopreservation and/or medical techniques developed to preserve sexual and/or reproductive function. The policy does not cover surrogacy or adoption services; however, AFP may be entitled to maternity leave, adoption pay and leave and/or paternity pay and leave. This should be discussed with an individual's CoC.

2816. Individual Medical Risk Assessment for Operational Deployments or High Readiness Roles

a. This policy provides instructions to individuals, Commanding Officers (COs) and Career Managers (CMs) on the requirement and process to conduct Individual Medical Risk Assessments (MRAs)[52] for RN and RM Regular and Reserve Service Personnel (SP) who are nominated for operational deployments or high-readiness roles.

b. The MRA allows the Chain of Command (CoC) to articulate, treat, and accept the residual risks of deploying (or holding at readiness) Service Personnel who are not fully medically deployable. This risk will be articulated to Commanders who may accept or reject the nominated individual.[53]

c. Personnel who have a Medical Deployment Standard (MDS) of below Medically Fully Deployable (MFD), typically Medically Limited Deployability (MLD), require a MRA for operational deployments or high readiness roles.[54] Specialist employment groups such as aircrew, occupational divers, and Special Forces deploying within role are considered out with this policy, unless they are deploying in a non-specialist role.

[52] Separate and distinct from Deployment Health Impact Assessments, Medical Plans and associated staff work output.
[53]PJHQ_SOP_1100-MRA_Proc
https://modgovuk.sharepoint.com/:b:/r/sites/IntranetUKStratCom/OfficialSensitiveDocuments/PJHQ_SOP_1100-MRA_Process-OS.pdf?csf=1&web=1&e=aKWKCcess-OS
[54] web.apps.royalnavy.r.mil.uk/fpgo/Pages/Med.htm, https://modgovuk.sharepoint.com/teams/3695/SitePages/JSP-950-Lft-6-7-7-Joint-Service-Manual-of-Medical-Fitness.aspx

d. **Requirement.** The CoC retains the authority to deploy personnel irrespective of their MDS in exceptional circumstances and after completing a risk assessment.[55] Therefore, to protect the health of individuals and maintain the operating capability of the deployed force, it is imperative that a Command-led objective assessment of an individual's ability to deploy is conducted with risks recorded and where required elevated.[56] The decision to deploy personnel with an MDS below MFD has the potential to increase the level of risk held by the Commander and must consider:

(1) **Risk to Health.** Defence has a duty of care to its personnel and must balance the health impact the activity may have, due to the inherent health risks present, against the operational justification of the activity.

(2) **Risk to Mission.** Deployment of personnel with a MDS below MFD may limit the ability of personnel to complete their full range of duties in their deployed role, including reasonable unexpected tasks and present additional risk to mission due to increased demand on medical services.

e. **Risk Management and Duty Holding.** Commanding Officers and the Military Command have a Duty Holding responsibility to appropriately select and prepare personnel for deployment, which may encompass an MRA. Once deployed, OPCOM, e.g. CJO[57], would have a Duty of Care to ensure that all personnel have been adequately prepared for deployment so that risks relating to activities are "As Low as Reasonably Practicable" (ALARP). As such, where doubt exists over the suitability of an individual for deployment, then the Commanding Officers, PJHQ, etc should be consulted for advice through the MRA and Deployment Waiver Process.[58]

f. **Responsibilities.**

(1) **Individual.** It is an individual's responsibility to know their Joint Medical Employment Standard (JMES) and articulate any JMES issues to their CoC and CM prior to any deployment or assignment; up to date JMES can be found on SCIO, JPA or in the MyNavy App. Where they are trawled for Individual Augmentation (IA) or OPDEF rectification **all Service Personnel and Line Managers** are to ensure that their JMES including Medical Limitations (MedLims) are entered into the professional considerations section of the Personnel Support Request (PSR); this applies irrespective of whether the Service Person (SP) is MFD, MLD or MND.

(2) **Career Manager.** When assigning individuals, the CM is responsible for checking the SP's JMES and whether there is any restriction which requires a MRA. The CM will inform the proposed CoC of the SP's JMES and the CoC will then initiate the MRA process.

[55] JSP 950 Lft 6-7-7. https://modgovuk.sharepoint.com/teams/3695/SitePages/JSP-950-Lft-6-7-7-Joint-Service-Manual-of-Medical-Fitness.aspx
[56] The majority of personnel will be assessed as suitable to deploy by a Unit Health Committee 3 (UHC) however a small percentage of MRAs will require elevation through the CoC, e.g. PJHQ through Front Line Commands (FLC) to confirm their suitability to deploy.
[57] Whilst not a formally recognised Duty Holder.
[58] PJHQ SOP 1100: Medical Deployment Risk Assessment and Waiver Process (Currently under review).

(3) **Formed Units.** It is the CO's responsibility to ensure that all personnel who meet the criteria for a MRA are assessed prior to deployment. Timelines for Theatre entry will normally be published by Theatre Commanders. It is the CO's responsibility to ensure a MRA is raised and submitted in good time. The CO should ensure that completed MRAs are retained in the SP's personnel records, per Annex 28B Section 7.

(4) **Unit Medical Officer (UMO).** The UMO is responsible for completing their section of the MRA and coordinating any Occupational Health (OH) input in good time as directed by their CO. The section should be completed, or counter-signed, by an accredited Defence General Practitioner (GP) if the UMO is not accredited. Referral to RNOHS is **mandatory** if the MDS is MND, MES L4 for Land Ops, MES E4 for any Ops, or 5500 MedLim has been awarded. Referral to RNOHS is **recommended** if there is uncertainty about supporting fitness for role. The CO is to ensure that completed MRAs are copied to the UMO for upload into the SP's Defence electronic healthcare record.

g. **Timelines.** For planned operational deployments, high-readiness roles, and overseas assignments, MRAs should be submitted at least six months and not later than 1 month before deployment or IAW Theatre Commander's instructions[59]. For short notice assignments and augmentation MRA should be submitted as soon as practicable. The requirement to meet these timelines also applies ahead of periods where personnel are nominated to be held at E/VHR.

h. **Medical Deployment Standard (MDS) and Medical Employment Standard (MES)**

(1) **Land.** MRAs are mandatory for SP graded MLD as this indicates the SP has a MES of L3 or L4, applicable to operational deployments and high-readiness roles. Further guidance is at Annex 28A.

(2) **Maritime.** MRAs are mandatory for SP graded MLD and/or where specific Medical Limitations (MedLims) have been awarded, applicable to operational deployments and high-readiness roles. Further guidance is at Annex A.

(3) **Air.** Non-aircrew and aviators who no longer require aircraft currency are typically awarded A4 and do not require a MRA to be flown in a passenger aircraft. Those awarded A5 may only by flown as an aeromedical evacuation patient.

(4) **Deployment of Medically Non-Deployable (MND) Service Personnel.** MND SP should not deploy overseas. However, for UK Ops or in exceptional circumstances an MRA may be conducted with UMO, OH, and Theatre CoC support, per Para 2816.d.

[59] Examples: PJHQ Pre-Deployment Information SharePoint page, Op KIPION: UKNSF New Joiners' Handbook, PJHQ SOP 1100: Medical Deployability Risk Assessment (currently under review).

(5) **Medical Risk Assessments for Routine Activities.** UK routine activities such as courses, exercises and ranges are detailed in extant policy and course Joining Instructions[60]. Overseas routine activity such as defence engagement and visits ashore does not typically require an MRA. However, activities which require a medical plan and/or are included on a Units' dynamic Risk to Life Register would normally require a MRA for SP graded MLD/MND. Where ambiguity arises or a specific risk is identified, a MRA should be completed.

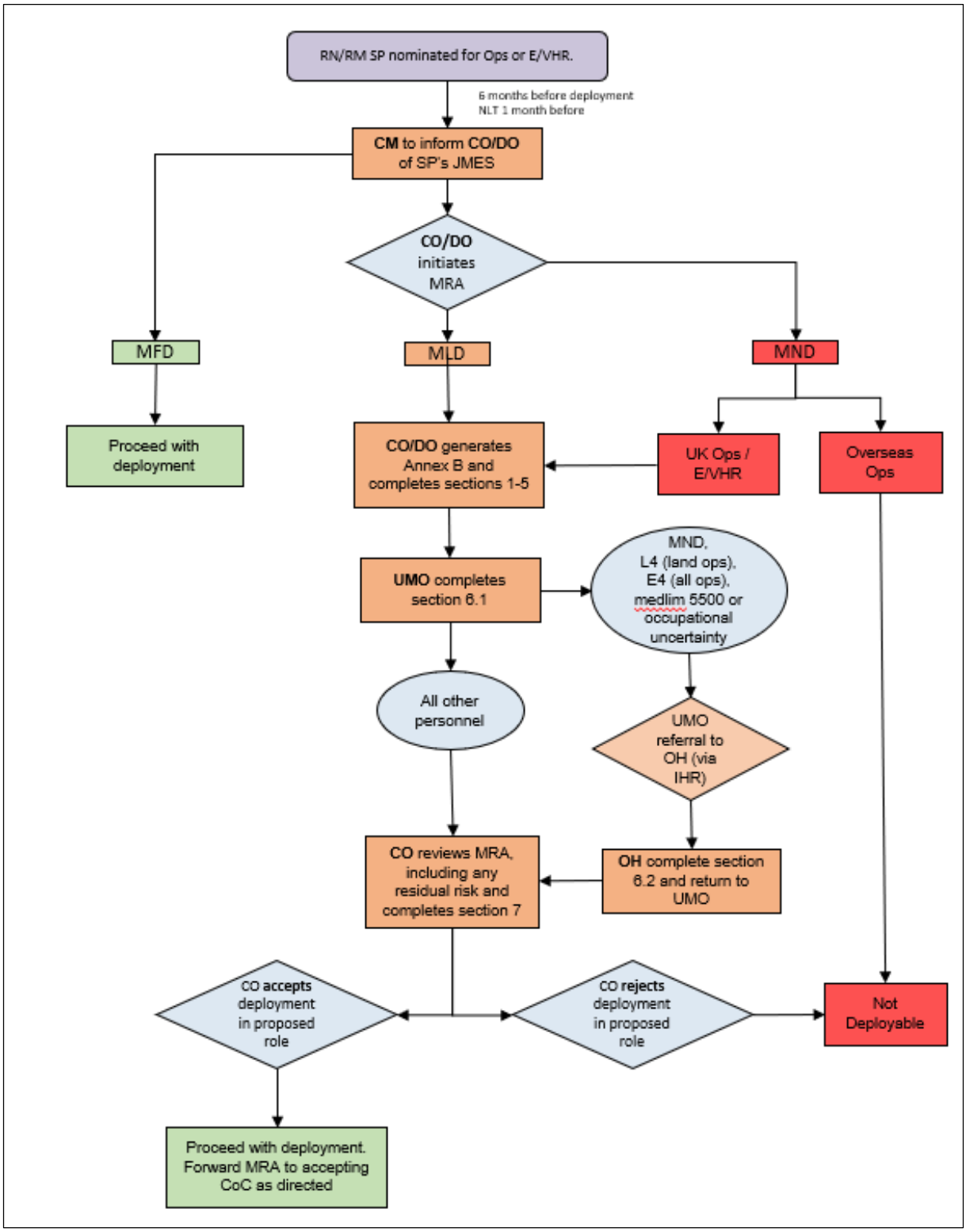
(6) The MRA requirement guide is available at Annex 28A to this chapter which should be conducted using the blank MRA template at Annex 28B.

(7) Where the deployment of single or multiple non-MFD SP is assessed as posing a Risk to Health or Mission, Commanders are to consider initiating a Health Risk Assessment (or amendment to an extant HRA) for submission to the Competent Medical Authority.[61]

[60] Examples: RNTM 07-071/24 JIs for SRLC and LRLC, JSP 419: Adventurous Training in the UK Armed Forces, JSP 950 Lft 1-2-12 Assessment of Medical Suitability to Attend Courses and Training.
[61] RNTM 06-007/25 Competent Medical Authority (CMA) Healthcare Impact Assessment (HIA) instructions for RN units.

ANNEX 28A

A COMMANDER'S GUIDE TO INITIATING MEDICAL RISK ASSESSMENTS



1. Referral to OH is mandatory if:

a. The MDS is MLD or MND

b. MedLim 5500 (MRA undertaken by OH prior to Exercise/PDT/deployment) has been awarded.

c. If the UMO has uncertainty in supporting fitness for deployed role without taking specialist OH advice, or if the UMO has specific concern.

ANNEX 28B

RN INDIVIDUAL MEDICAL RISK ASSESSMENT (MRA) FORM

RN INDIVIDUAL MEDICAL RISK ASSESSMENT (MRA) FORM
(Downloadable version available in BRd 3(1) Forms Section)